PATIENT REGISTRATION

Last Name: ______________________ **First Name:** ______________________ **MI:** ________

Date Of Birth: ______________

ACCOUNT TYPE: ☐ Cash/Self-Pay ☐ Insurance ☐ Lien ☐ Workman's Comp

INSURANCE COMPANY INFORMATION:

Primary Insurance Company Name: ______________________________

Claims Address: ______________________________

Policy Holder Name: ______________________ **Date Of Birth:** ______________

Policy Holder Employer: ______________ **Policy Holder SSN:** ______________

Policy Number/ID: ______________________ **Group Number:** ______________

Relationship To The Patient: (Check One) ☐ Self ☐ Spouse ☐ Child ☐ Parent ☐ Other: ____________

Secondary Insurance Company Name: ______________________________

Claims Address: ______________________________

Policy Holder Name: ______________________ **Date Of Birth:** ______________

Policy Holder Employer: ______________ **Policy Holder SSN:** ______________

Policy Number/ID: ______________________ **Group Number:** ______________

Relationship To The Patient: (Check One) ☐ Self ☐ Spouse ☐ Child ☐ Parent ☐ Other: ____________

INSURANCE AUTHORIZATION AND ASSIGNMENT OF BENEFITS:

I certify that the information that I have reported with regards to my insurance coverage is correct. I also authorize the release of any medical information necessary to process this claim. I also authorize payment of medical benefits to Serge C. Kaska MD. I fully understand that payment for services is not contingent upon recovery and this does not relieve me of my primary obligation to pay.

Signature: ______________________________ **Date:** ______________

Medicare Patients Only:

Do You Currently Reside In A Skilled Nursing Facility? ☐ Yes ☐ No

In Medicare cases, Serge C. Kaska, MD, agrees to accept the charge determination of Medicare as the full charge, and the patient is responsible only for deductible, coinsurance and non-covered services. Coinsurance and the deductibles are based upon the charge determination of Medicare.

Signature: ______________________________ **Date:** ______________

In compliance with the American Recovery and Reinvestment Act of 2009 (AARA) to demonstrate Meaningful Use, we are required to capture demographic data including your preferred language, race and ethnicity.

Serge C. Kaska, MD | 277 Rancheros Drive Suite 101, San Marcos, CA 92069 | p. 760.750.1902 f. 760.750.1906 | **drkaska.com**

PATIENT FINANCIAL AGREEMENT

Your Responsibilities and Acknowledgments:

The patient or the patient's Legal Representative* is responsible for the following:

- Determine if Serge C. Kaska, MD is a participant in your medical insurance plan.
- Know what services are covered by your medical insurance. The cost of any service NOT covered by insurance is the responsibility of the patient, and will be billed in full to the patient.
- Ensure we have your correct medical insurance and address information. Our office will bill your insurance for services rendered.
- Pay your deductible and/or co-payment at the time of the visit, before services are rendered. If co-payment is not paid at that time, our office may charge an additional administrative fee of $20.
- Our office will bill the patient for balances due from co-insurance, deductibles, or for non-covered services.
- All outstanding charges shall be paid within the initial billing cycle - 30 days.
- We request at least 24 hour notice if you must cancel or reschedule an appointment.
- A Self-Pay/Cash Patient is one who does not have medical insurance that covers Serge C. Kaska, MD. Self-Pay/Cash Patients are expected to pay in-full at the time services are rendered, unless other arrangements have been made. Please contact our office to make prior arrangements for payment.
- Payments may be made via VISA, MasterCard, Cashier's Check or Cash. Personal checks are **not** accepted.
- Overdue accounts shall be sent to a collections agency or may be subject to legal action. Relevant personal and account information will be released in this course of action. The costs of such action shall be added to the patient's outstanding balance.

*Legal Representative is defined as the parent of a minor child or person named in a legal document such as a Power of Attorney or Guardianship. Please provide us a copy of the pertinent legal document.

I agree to these terms and acknowledge that this is a binding agreement.

____

Print Name of Patient or Patient's Legal Representative

____

Signature of Patient or Patient's Legal Representative

____

If Legal Representative, State Relationship to Patient

____

Date

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HIPAA - RELEASE OF PROTECTED HEALTH INFORMATION

TO BE COMPLETED BY PATIENT

Please list the family members, significant others, or other persons, if any, whom we may inform about your general medical condition and your diagnosis. This may also include treatment plan, prognosis, payment information and health care options:

Name:_____________________________ **Relationship:**____________________ **Phone:**(____)______________

Name:_____________________________ **Relationship:**____________________ **Phone:**(____)______________

Name:_____________________________ **Relationship:**____________________ **Phone:**(____)______________

Please list family members, significant others, or other persons, if any, whom we may inform about your medical condition ***ONLY IN AN EMERGENCY***:

Name:_____________________________ **Relationship:**____________________ **Phone:**(____)______________

Name:_____________________________ **Relationship:**____________________ **Phone:**(____)______________

Please print the telephone number where you want to receive calls about your appointments, labs, and x-ray results or other health care information. This may include surgery scheduling information, and post-operative instructions:

Home:(____)__________________________________ **Mobile:**(____)__________________________________

(I am fully aware that a mobile phone is not a secure and private line)

Do you wish to communicate with our office via email? ☐ **Yes** ☐ **No**
(Consider e-mail like a postcard that can be viewed by unintended persons.)

I have requested to correspond using email. I understand that there is no guarantee of confidentiality using email. **Initial:** ______________

May confidential messages (i.e. appointment reminders) be left on your answering machine or voicemail?
☐ **Yes** ☐ **No**

____ ____

Signature of Patient or Legal Guardian **Date**

NOTE: Uses and disclosures of health information may be permitted without prior consent in an emergency.

PRIVACY PRACTICES ACKNOWLEDGEMENT

NOTE: A copy of our office Privacy Policy is available upon request.

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

____ ____

Please Print Patient Name **Date of Birth**

____ ____

Signature of Patient or Legal Guardian **Date**

If not signed by the patient, please indicate relationship:
☐ Parent or guardian of minor patient
☐ Guardian or conservator of an incompetent patient
☐ Beneficiary or personal representative of deceased patient

Name of Representative:____

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